

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



December 6, 2001

ALL-COUNTY INFORMATION NOTICE NO. I-107-01

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS
ALL COUNTY WELFARE FISCAL OFFICERS

Reason For This Transmittal

- ☐ State Law Change
- ☒ Federal Law or Regulation Change
- ☐ Court Order or Settlement Agreement
- ☐ Clarification Requested by one or More Counties
- ☐ Initiated by CDSS

**SUBJECT: CHANGE TO THE CONTRACT EXPENDITURE (SOC 432) FORM TO
IMPLEMENT THE INCREASE IN FEDERAL MEDI-CAL ASSISTANCE
PERCENTAGE**

The purpose of this letter is to provide information about revisions to the Claim for Reimbursement In-Home Supportive Services Program Contract Expenditures (SOC 432). This form has been revised to reflect an increase in the federal financial participation for Personal Care Services Program (PCSP) costs.

The federal sharing ratio will increase from 51.25 to 51.40 percent effective October 1, 2001. The sharing ratios for the non-federal portion for PCSP costs (48.60 percent of the total PCSP cost) will remain at 65 percent for the State and 35 percent for the County. The Non-PCSP sharing ratios for State and County remain the same.

Also, counties contracting for services delivered in the In-Home Supportive Services (IHSS) Program are reminded of the need to forward a letter to the State with sample signatures of the person(s) authorized to sign the form. This information allows the State to verify that the appropriate county personnel are certifying and approving the form for auditing purposes. The persons authorized to sign must be the county welfare director or the contract administrator or their representative, and the county auditor or the county controller or their representative. Counties should provide a new letter of authorized signatures whenever there is a change for the person(s) that are authorized to sign.

Please feel free to make copies of the forms. If counties would like a "Camera Ready" copy of the form, please contact the Department's Forms Management Unit at (916) 657-1984. For further information or clarification on the contents of this notice please contact your Adult Programs Operations Analyst at (916) 229-4000.

Sincerely,

***Original Document Signed By
Donna L. Mandelstam on 12/4/01***

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

Attachment

CLAIM FOR REIMBURSEMENT IN-HOME SUPPORTIVE SERVICES PROGRAM CONTRACT EXPENDITURES

To: Adult Programs Branch
California Department of Social Services
744 P Street, MS 19-96
Sacramento, CA 95814

FROM:

COUNTY:

ADDRESS:

CONTACT PERSON:

PHONE NUMBER:

()

CONTRACT NUMBER

CONTRACTOR NAME

SERVICE MONTH/YEAR

CONTRACT SERVICE DELIVERY TOTALS FOR MONTH BY FUNDING SOURCE:

WARRANT DATE _____

FISCAL YEAR/QTR. _____

FUNDING SOURCE	TOTAL CASES	TOTAL HOURS	GROSS EXP.	*ADJUSTMENTS	TOTAL NET EXP.
PCSP	_____	_____	_____	_____	_____
Non-PCSP	_____	_____	_____	_____	_____
Totals	_____	_____	_____	_____	_____

* If the actual PCSP and Non-PCSP adjustment amounts are not known, please estimate the PCSP and Non-PCSP amounts based on the PCSP and Non-PCSP hours to total hours ratio.

COST REIMBURSEMENT DETAIL BY FUNDING SOURCE:

FUNDING SOURCE	FEDERAL	STATE/COUNTY	STATE	COUNTY	TOTAL NET EXPENDITURE
PCSP	(51.40%) _____	(48.60%) _____	(65%) _____	(35%) _____	_____
Non-PCSP	_____	_____	(65%) _____	(35%) _____	_____
Total	_____	_____	_____	_____	_____

I hereby certify, under penalty of perjury, that I am the official responsible for the administration of the Personal Care Services Program; that I have not violated any of the provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 Welfare and Institutions Code personal care services as a benefit for the categorical eligible; and the provisions of Section 1090 to 1096, inclusive of the Government Codes; that the amounts claimed herein are properly claimable as expenditures for the administration of the project as specified in accordance with all provisions of the Welfare and Institutions Codes, the rules and regulations of the State Benefits and Services Advisory Board.

I hereby certify under penalty of perjury, that I am the official responsible for the examination and settlement of accounts, that I have not violated any provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 Welfare and Institutions Code personal care services as a benefit for the categorical eligible; and the provisions of Sections 1070 to 1096, inclusive, of the Government Code; that the expenditures claimed herein have been authorized, that a clearly delineated audit trail is in place to substantiate said expenditures, and that payments therefore have been made or expenditures otherwise incurred according to law.

SIGNATURE OF COUNTY WELFARE DIRECTOR OR CONTRACT ADMINISTRATOR

DATE

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER

DATE

Approved by: _____ Date _____
(State IHSS Program Manager)

SECTION I**OVERPAYMENTS/UNDERPAYMENTS**

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
A	PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)
B	CONNECTED PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)
C	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)

SECTION II**OTHER****(COUNTY SPECIFIC)**

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
D	BILLED	(1)	(2)	(3)	(4)	(5)	(6)
E	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
F	NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)

SECTION III**LIQUIDATED DAMAGES**

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
G	BILLED	(1)	(2)	(3)	(4)	(5)	(6)
H	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
I	NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)

SECTION IV**PCSP / IHSS ADJUSTMENTS**

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
J	NET ADJUSTMENT C + E + H (+ / =)	(1)	(2)	(3)	(4)	(5)	(6)
K	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
L	TOTAL NET ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)

SECTION V**CONTRACTOR BILLING**

	SERVICE MONTH (1)	TOTAL PCSP CASES	TOTAL IHSS CASES	TOTAL PCSP HOURS	TOTAL IHSS HOURS	TOTAL PCSP GROSS	TOTAL IHSS GROSS
M	INVOICE BILLED	(1)	(2)	(3)	(4)	(5)	(6)
N	NET ADJUSTMENT + / = C + E + H OR L	(1)	(2)	(3)	(4)	(5)	(6)
O	TOTAL NET ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
P							